Green Mountain Care Board
144 State Street
Montpelier, VT 05601
January 3, 2020

Re: Northwestern Medical Center Emergency Department renovation
CON Docket No. GMCB-003-19con

To the Green Mountain Care Board:

We would like to make a few observations in response to the December 23 reply of Northwestern Medical Center to the Board's questions of November 19 regarding the comments we submitted on November 11 as well as those submitted by the Department of Mental Health on November 14.

We note that the issue presented is whether spending an excess of $7,600,000 on emergency room modernization meets certificate of need criteria, specifically in terms of whether the planned design of the psychiatric sub-unit – cited as a critical aspect of the need for the project – meets the needs of patients in a way that "will support equal access to appropriate mental health care that meets standards of quality, access, and affordability equivalent to other components of health care as part of an integrated, holistic system of care, as appropriate." This application fails in two regards that remain unresolved in the NMC response.

First, although CMS standards provide guidance regarding safety and quality of care, they do not (as NMC implicitly acknowledged) identify best practices or emerging trends, which is what would be expected in making major investment of health care resources to retain value well into the future. The Rutland Regional Medical Center emergency room was approved in 2016, prior to the adoption of Criteria #9 by the legislature in 2018, and it was thus not reviewed by the Department of Mental Health. The strong reliance by NMC on RRMC's design and on the recommendations of CMS misses the point of Criterion #9, which places mental health quality of services on an equal footing with investments that would be expected for any other patients. In addition, NMC asserts that it "mimicked" the RRMC design, yet that emergency department design included a "multipurpose room" that would allow for the clinical need for a common area/patient meeting area for emergency department care. (See attachment, page 12, from Lavallee/Brensinger Architects) Furthermore, there have already been discussions at RRMC about the need for revisions to make its psychiatric ED space more conducive to good patient care.

This necessary space is for appropriate emergency department care, not remotely equivalent to the extensive needs of an inpatient unit. As we referenced previously, there are patient support requirements for involuntary patients in the ED that are mandated by law. There is also an emerging best practice for psychiatric emergencies called the "Collaborative Network" approach, already in use in Vermont, which requires adequate space for clinicians and patients to meet together with family and other support persons. [It is unclear to us how the space in the RRMC design is currently being utilized. From the attached power-point presentation from the architectural firm, it appears that its utility may have been reduced because of poor layout planning, as the location of the multipurpose room at the end of the hall is listed as a drawback, "better located in the middle of the unit." This should have been a "lesson learned" from RRMC, rather than eliminating it from a plan that NMC said was modeled on the Rutland facility.]

We noted previously that the concerns that led to our submitting comments on the NMC CON arose as a result of our involvement in current planning for psychiatric resources in the EDs for both CVMC and UVMMC. Both of those plans incorporate an area that allows for patient mobility and contact with

others while in the ED – a further clear indication of this as an integral component of emergency department care for psychiatry.

To allow expenditure of $7,616,214 on an "ED modernization project" that omits from its design a single commonly-accessible patient area for multiple support uses that is crucial to meeting psychiatric patient needs appropriately within the ED would mean approval of a major financial investment despite the lack of an essential patient care resource, resulting in the quality of mental health care not being equivalent to other components of health care, in violation of Criterion #9.

Secondly, authorization of construction of a segregated psychiatric area that introduces a capacity for locked detention, without the assurance that it will only be used for patients who are in state custody, is also a direct violation of equitable treatment among patients, and has no authority under state law. Rather than provide such an assurance NMC has now directly indicated that it does intend to use the locked holding area for patients who have come to the ED voluntarily seeking help, and will use policies and procedures, yet to be established, that will use clinical rather than legal criteria.

NMC states that "designation of voluntary versus involuntary or the designation of custody do not necessarily align with the reality of a patient's potential or intent to harm themselves or others." NMC is thereby asserting the intent to opt to use locked detention in circumstances that do not meet legal criteria for detaining patients. State law precisely sets out when it is permissible to hold individuals against their will: when a person is a danger to themselves and others *and is refusing treatment*. In situations NMC describes, if the patient is refusing treatment and creating a danger, hospital personnel can immediately act to have the patient placed in emergency temporary custody of the Commissioner of Mental Health. That is the appropriate, and legal, route that was created by statute for addressing such circumstances.

As noted in the Vermont Patient Bill of Rights, "The patient has the right to refuse treatment to the extent permitted by law." The law on involuntary psychiatric treatment is explicit, and NMC proposes in this CON to block the right to refuse treatment, outside of what is permitted by law.

When patients are not in DMH custody, they have the ability to make a voluntary choice about admission to a locked inpatient unit. This proposal would allow for detention in an emergency room with neither the voluntary, informed choice of the patient nor the legal protections of the law. [We note that a well-designed and welcoming, therapeutic ED space that is locked based upon needs of the minority of patients who are in state custody may be a more attractive choice for voluntary patients who would otherwise be waiting in a single room. *Allowing that option is not involuntary detention.* Both the CVMC and UVM space planning assume that a majority of voluntary patients waiting for assessment or admission will choose to be in the specially designed psychiatric area, even though it is locked.]

NMC is not proposing to lock in other patients who have behavioral symptoms that may create a danger, despite any number of health care conditions that can result in aggression or dangers to self and despite dangerous behaviors exhibited by other patients that are not related to health symptoms. As NMC notes, it has an obligation to keep all patients safe, yet it only proposes a locked subsection if the cause is believed to be psychiatric in nature. This is not equitable treatment.

NMC is not without the ability to use alternative means to ensure safety, if it has adequate, trained staff to address behavioral emergencies for any and all patients. If it argues a lack of adequate resources for monitoring psychiatric patients, then this is an insurance reimbursement parity issue, not a basis for locking up patients for staffing efficiency. The new language of Criteria 9 was, in the same year, also included in state law pertaining to insurance rate review and indeed, to every section of state law that pertained to health care oversight.

Because NMC has explicitly stated its intent to construct and use a locked section of the emergency room for patients who have not provided informed consent and who are not in state custody, granting a certificate of need for its construction would be authorizing a violation of legal rights of psychiatric patients

It is inequities in the care provided to patients with psychiatric disabilities that led to our shameful health system neglect and abuses for so many decades, and which Vermont laws have been seeking to redress since 1997. Now is not the time to permit regression through permitting the design and construction of new ED facilities that introduce locked detention in an emergency department in lieu of appropriate care. Such a project will not "support equal access to appropriate mental health care" and will not meet "standards of quality, access, and affordability equivalent to other components of health care."

Sincerely,

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